

## REQUESTING YOUR IMMUNIZATION RECORD

**NOTE:** Before beginning this process, it may be faster to request a copy of your immunization record electronically via the My Vax Records Patient Portal or from your current healthcare provider. If that is not possible, please read this information and complete the form below to request a paper copy of your immunization record, including your record of COVID-19 vaccination.

To obtain a copy of your immunization record, we use the Massachusetts Immunization Information System (MIIS), a web-based system that keeps track of all immunizations that healthcare providers administer to children and adults in Massachusetts. The system was established in 2011 and is operated by the Massachusetts Department of Public Health (MDPH) according to state law ([M.G.L c. 111, Section 24M](#)).

**All individual information in the MIIS is kept confidential in accordance with applicable law.**

To obtain your Immunization Certificate from MDPH, please submit the following and we will make every effort to respond within 10 business days.

- An Immunization Record Request Form, fully completed and signed and notarized
- A photocopy of your driver's license, or other state-issued ID, with the license number shielded or removed
- If you have experienced a name change in the last 10 years, please submit proof of legal name change
- If your new address is not reflected on your ID, please submit proof of your new address (e.g. a copy of a utility bill)

**\*Please note – the Immunization Certificate generated from the MIIS may or may not be a complete representation of the most current immunization status.** According to Massachusetts state law, healthcare providers and other licensed professionals must report administered vaccinations to the state; however, it is possible your provider has not yet: a) been registered to use the system; or, b) entered complete immunization history into the system. **Therefore, MDPH may be unable to provide you with an Immunization Certificate or may only be able to provide you with a partial record.** In this case, you will have to contact your healthcare provider to obtain your immunization records.

**Please return the completed paperwork to MDPH by mail or fax:**

My Vax Records  
Massachusetts Immunization Information System (MIIS)  
Massachusetts Department of Public Health, Immunization Division 305  
South Street, Jamaica Plain, MA 02130

FAX: 857-323-8321

**DO NOT SUBMIT VIA EMAIL – MIIS EMAIL IS NOT SECURE**

# MDPH Immunization Record Request – Page 1 of 2

## Immunization Record Request Form

**Information on Record being requested:** This information is necessary to ensure the identity of the individual whose record is being requested (*i.e. you, your child, or individual over whom you have legal authority*).

NAME:

\_\_\_\_\_  
LAST FIRST MIDDLE

DATE OF BIRTH: \_\_/\_\_/\_\_\_\_ GENDER: \_\_\_\_\_ PHONE NUMBER: \_\_\_\_\_  
MM/DD/YYYY

ADDRESS: \_\_\_\_\_  
STREET CITY STATE ZIPCODE

MOTHERS MAIDEN NAME: \_\_\_\_\_  
IF AVAILABLE FOR INDIVIDUAL YOUNGER THAN 18 YEARS OF AGE

**Information on Requestor of the record:** This information is necessary to ensure the individual/agency has the legal authority to complete this record request.

Requestor same as above – skip to **Signature of Requestor**, otherwise complete section below.

NAME:

\_\_\_\_\_  
LAST FIRST MIDDLE

ADDRESS: \_\_\_\_\_  
STREET CITY STATE ZIPCODE

PHONE NUMBER: \_\_\_\_\_

I authorize the Massachusetts Department of Public Health to release the requested record to:

SELF       HEALTHCARE PROVIDER       SCHOOL       OTHER  
AGENCY

AGENCY NAME: \_\_\_\_\_ VIA FAX: \_\_\_\_\_

AGENCY PHONE: \_\_\_\_\_

VIA MAIL:

\_\_\_\_\_  
STREET CITY STATE ZIPCODE

## MDPH Immunization Record Request – Page 2 of 2

I authorize the Massachusetts Department of Public Health to release confirmation of record processing to the following:

Email: \_\_\_\_\_

If you do not have access to an email, you may request confirmation via Fax or Phone:

Fax: \_\_\_\_\_

Phone: \_\_\_\_\_

SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

**Signature of Requestor:** I am requesting my own record, or I am the parent, guardian, or other person authorized to act for the person whose record I am requesting. I certify under the penalties of perjury that the information I am providing to request the identified immunization record is true to the best of my knowledge.

### Verification: To be completed by a certified notary public

STATE OF \_\_\_\_\_  
\_\_\_\_\_ County, ss.

OFFICIAL SIGNATURE AND SEAL OF NOTARY:

On this \_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_,  
before me, the undersigned notary public,  
personally appeared

\_\_\_\_\_  
proved to me through satisfactory evidence of  
identification, which were  
\_\_\_\_\_, to be the person  
whose name is signed on this document in my  
presence. And has produced documentation to  
confirm legal authority if requesting on behalf of  
another person.

\_\_\_\_\_  
Notary Public

\_\_\_\_\_  
Commission # \_\_\_\_\_ My commission expires \_\_\_\_\_